State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DEPARTMENT OF HEALTH CARE SERVICES
HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER
FREEDOM OF CHOICE LETTER/DOCUMENT

Date:

Client Name:
C/O Caregiver's Name:
Address:
City/State/Zip:

Dear _____:

The Department of Health Care Services, Medi-Cal Operation Long Term Care Division, has received a request for *HCBS Waiver services* for the Client above under the Assisted Living Waiver. This HCBS Waiver is intended to provide Medi-Cal beneficiaries with a choice to reside in an assisted living setting as an alternative to care in a nursing facility.

Whether accepting or declining these services, the Department is required to obtain written confirmation of your choice.

Your acceptance or refusal of Assisted Living Waiver services is based on the following:

You or your authorized representative has been informed of the services available to you under the waiver as an alternative to care in a skilled nursing facility.

1. You have the right to choose an HCBS Waiver service provider who has been identified under the waiver as an able provider of the service(s) requested; and,

2. You are aware of your role and responsibility, and that of the providers, in the waive
program.

After you have selected, signed, and dated the enclosed Freedom of Choice Document, please return it to your Care Coordinator.

DEPARTMENT OF HEALTH CARE SERVICES
HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER
FREEDOM OF CHOICE LETTER/DOCUMENT

If you **agree** to accept the *HCBS Assisted Living Waiver Services* as an alternative to care in a skilled nursing facility, please check the "**Accept**" box below, print your name, date the form, and sign your name. If you are unable to sign the form, your authorized representative should then complete the form as indicated.

☐ Accept HCBS Assisted Living Waiver

_____
Client or Authorized Representative Signature

_____
Printed Name of Client or Authorized Representative Date Signed: _____

If signed by Authorized Representative:

_____
Relationship to Client

If you **do not agree** to accept the *HCBS Assisted Living Waiver Services* as an alternative to care in a skilled nursing facility, or have other alternatives available to you, please check the "**Decline**" box below, print your name, date the form, and sign your name. If you are unable to sign the form, your authorized representative should complete the form as indicated.

☐ Decline HCBS Assisted Living Waiver

_____
Client or Authorized Representative Signature

_____
Printed Name of Client or Authorized Representative Date Signed: _____

If signed by Authorized Representative:

_____
Relationship to Client